DISTRICT OF COLUMBIA
DEPARTMENT OF INSURANCE AND SECURITIES REGULATION

NOTICE OF FINAL RULEMAKING

The Acting Commissioner of Insurance and Securities Regulation, pursuant to the authority set forth in section 23 of the District of Columbia Health Maintenance Organization Act of 1996, effective April 9, 1997, D.C. Law 11-235, D.C. Code § 35-4522 (1997), hereby gives notice of the adoption of an amendment to Title 26 of the District of Columbia Municipal Regulations (DCMR) (Insurance). The purpose of the amendment is to add a new Chapter 35 to establish requirements, standards, and procedures for the formation and operation of Health Maintenance Organizations ("HMOs") in the District of Columbia. Several technical changes have been made to the text of the proposed rulemaking as published in the D.C. Register on June 25, 1999, at 46 DCR 5580. These rules will become effective upon the publication of this notice in the D.C. Register.

Title 26 DCMR (Insurance) is amended by adding a new Chapter 35 to read as follows:

Chapter 35 HEALTH MAINTENANCE ORGANIZATIONS (HMOs)

3500 ESTABLISHMENT OF HEALTH MAINTENANCE ORGANIZATIONS

3500.1 Any person seeking to operate an HMO in the District of Columbia shall file an application for a certificate of authority accompanied by the required supporting documentation with the Commissioner of Insurance and Securities Regulation ("Commissioner"), and pay a filing fee in the amount of five hundred dollars ($500).

3500.2 The application for a certificate of authority shall be accompanied by the following supporting ducumentation:

(a) A copy of the organizational documents of the applicant such as the articles of incorporation, articles of association, partnership agreement, trust agreement, or other applicable documents and all amendments thereto;

(b) A copy of the by-laws, rules and regulations or similar documents regulating the conduct of the internal affairs of the applicant;

(c) A list of the names, addresses, official positions and biographical information for those persons

responsible for the conduct of the affairs and day-to-day operations of the applicant, including:

(1) the members of the board of directors, board of trustees, executive committee, or other governing body; and

(2) the principal officers in the case of a corporation, or partners or members in the case of a partnership or association;

(d) A sample of any contract form made, or to be made, between any class of providers and the HMO and a copy of any contract form made, or to be made, between third party administrators, marketing consultants or persons listed in paragraph (c) and the HMO;

(e) A copy of the form of evidence of coverage to be issued to the enrollees;

(f) A copy of the form of group contract, if any, to be issued to employers, unions, trustees or organizations;

(g) Financial statements showing the applicant's assets, liabilities, and sources of financial support, including both a copy of the applicant's most recent certified financial statement and an unaudited current financial statement;

(h) A financial feasibility plan (except for a person that holding an unencumbered certificate of authority to operate an HMO in Maryland or Virginia) which shall include:

(1) detailed enrollment projections;

(2) methodology for determining dues to be charged during the first 12 months of operation as certified by an actuary;

(3) projection of balance sheets;

(4) cash flow statements showing any capital expenditures;

(5) purchase/sale of investments and deposits with the District government;

(6) income and expense statements anticipated from the start of operations until the

organization has had net income for at least one (1) year; and

(7) sources of working capital as well as any other sources of funding.

(i) If not domiciled in the District, the applicant shall execute a power of attorney appointing the Commissioner, or his or her successors in office and duly authorized deputies, as the true and lawful attorney of the applicant in and for the District upon whom all lawful process in any legal action or proceeding against the HMO on a cause of action arising in the District may be served;

(j) A statement and map of the geographical area or areas to be served;

(k) A description of the proposed quality assurance program;

(l) A description of procedures to be implemented which meet the requirements for protection against insolvency as required under section 13 of the Act, D.C. Code § 35-4512;

(m) A list of the names, addresses and license numbers of providers that have agreements with the HMO, provided that:

(1) the license numbers of the providers shall be maintained in the HMO's administrative office; and

(2) the list of the license numbers shall be available for review by the Commissioner during on-site visits;

(n) The method of determining situs of each group contract;

(o) Any other information the Commissioner deems necessary to make the determination whether to issue a certificate of authority.

3500.3 After receiving its certificate of authority, an HMO shall submit to the Commissioner information concerning any modification or amendment to the information contained in its orignal application for a certificate of authority and supporting documentation prior to effecting a modification or amendment for the items listed in subsection 3500.2(a) through (f), (h)(5), and

(o). Information or supporting documentation for an amendment for items not listed in this subsection shall be provided to the Commissioner at the next succeeding site visit or examination.

3500.4 The Commissioner shall have thirty (30) days to approve a modification or amendment when his or her approval is required. On written notice to the applicant, an additional thirty (30) days may be taken by the Commissioner, if additional time is needed to properly consider the modification or amendment. If the Commissioner fails to disapprove the modification or amendment within the original thirty (30) day period, as extended by any additional period of thirty (30) days, the application will be considered approved.

3500.5 Licensure packages may be requested from the Department of Insurance and Securities Regulation, Insurance Bureau, Consumer and Professional Services Division.

3501 ISSUANCE OF CERTIFICATE OF AUTHORITY

3501.1 The Commissioner, in consultation with the Director of the Department of Health, shall determine whether the applicant has complied with the District's quality assurance program, pursuant to section 7 of the Act, D.C. Code § 35-4506, with reference to health care services.

3501.2 Within forty-five (45) days of the receipt of an application for a certificate of authority, the Commissioner shall certify that the proposed HMO meets the District's quality assurance program.

3501.3 The forty-five (45) day review period to determine whether an applicant complies with the District's quality assurance program will be tolled when additional information is requested.

3501.4 Written notice shall be given informing an applicant when it does not meet the requirements of the District's quality assurance program. The notice shall specify the deficiencies.

3501.5 The Commissioner shall issue a certificate of authority when the following requirements are satisfied:

(a) A completed application is filed;

(b) Prescribed fees are paid;

(c) Persons responsible for the conduct of the affairs

of the applicant are: competent, trustworthy, and operate an organization in good standing in the jurisdiction in which the organization currently conducts business; and have not been convicted of any criminal offense or engaged in fraudulent activity;

(d) All deficiencies identified by the Commissioner have been corrected and the HMO's proposed plan of operation meets the District's quality assurance program requirements;

(e) The HMO provides or arranges for the provision of basic health care services on a prepaid basis, through insurance or otherwise, except for copayments and deductibles;

(f) The HMO is in compliance with the protection against insolvency provisions under section 13 of the Act, D.C. Code § 35-4512; and

(g) The HMO complies with the enrollment period and replacement coverage provisions under section 15 of the Act, D.C. Code § 35-4512, in the event of insolvency.

3502 **POWERS OF HMOs**

3502.1 The powers of an HMO include, but are not limited to, the following:

(a) The purchase, lease, construction, renovation, operation or maintenance of hospitals, medical facilities, or both, and their ancillary equipment, and such property and equipment as may be reasonably required by the HMO for its principal office or for such purposes as may be necessary for transacting the organization's business;

(b) Conducting transactions between affiliated entities; and

(c) Contracting with any person for the performance of marketing, enrollment and administration functions.

3502.2 The exercise of any power under subsection 3502.1 which does not have a monetary value in excess of ten percent (10%) of the admitted assets or 25% of the HMO's net worth as reflected on the most recent quarterly report filed with the Commissioner shall be deemed "de

minimus" and no approval shall be required from the Commissioner.

3502.3 A request by the HMO to exercise a power is considered approved if the Commissioner fails to disapprove the request within thirty (30) days of the filing of the notice.

3502.4 Joint marketing with an insurance company is permissible as long as each product is clearly identified with the company making the offer.

3503 QUALITY ASSURANCE PROGRAM

3503.1 An HMO shall continually maintain an internal quality assurance program. This program shall monitor and evaluate the services provided by the HMO, including primary and specialist physician services, and ancillary and preventive health care services, across all institutional and noninstitutional settings.

3503.2 At a minimum the internal quality assurance program shall include at a minimum, the following items:

(a) A written statement of goals and objectives that emphasizes improved health status in evaluating the quality of care rendered to enrollees;

(b) A written quality assurance plan that describes:

(1) the HMO's scope and purpose in quality assurance;

(2) the organizational structure responsible for quality assurance activities;

(3) contractual arrangements for delegation of quality assurance activities;

(4) policies and procedures for confidentiality;

(5) a system of ongoing evaluation activities;

(6) a system of focused evaluation activities;

(7) a system for credentialing providers and performing peer review activities; and

(8) the duties and responsibilities of the designated physician responsible for quality assurance activities;

(c) A written description of the system of ongoing quality assurance activities which shall include:

(1) problem assessment, identification, selection, and study;

(2) corrective action, monitoring, evaluation, and reassessment; and

(3) interpretation and analysis of patterns of care rendered to individual patients by individual providers;

(d) A written statement describing the system focused quality assurance activities based on representative samples of the enrolled population which identifies the method of topic selection, study, data collection, analysis, interpretation, and report format; and

(e) A written plan for taking appropriate corrective action whenever inappropriate or substandard services have been provided to enrollees or services that should have been provided to enrollees have not been provided.

3503.3 The HMO shall record proceedings of formal quality assurance program activities and maintain documentation in a confidential manner.

3503.4 Minutes from the quality assurance program shall be available to the Commissioner.

3503.5 The HMO shall ensure the use and maintenance of a patient record system to facilitate the documentation and retrieval of clinical information for the purpose of evaluating the continuity and coordination of patient care, and assessing the quality of the health and medical care rendered to enrollees.

3503.6 The Commissioner or his or her authorized designee may review the clinical records of an enrollee to determine whether the HMO has complied with this section or for any other purposes he or she considers necessary.

3503.7 The HMO shall establish a mechanism for the governing body, providers, and appropriate staff to receive periodic reports on quality assurance program

activities.

3503.8 Quality assurance programs approved by the States of Maryland or Virginia, or by the District of Columbia Medicaid Program shall be deemed approved.

3503.9 When an applicant has received a certificate of authority from Maryland or Virginia, a Quality Assurance Program Inquiry form shall be filed with the initial application for certificate of authority in the District. The HMO shall submit a copy of the quality assurance report.

3503.10 The discussions between a patient and provider concerning medical treatment options and the financial coverage of those options shall not be prohibited, impeded or interfered with by the provider's contract with the HMO.

3503.11 The contract between the HMO and the provider shall permit the provider to discuss medical treatment options with its patients.

3503.12 An HMO's decision to terminate or refuse to contract with a provider shall not be based in whole or in part on the fact that the provider discussed medical treatment options with the enrollee.

3504 REQUIREMENTS FOR CONTRACTS AND EVIDENCE OF COVERAGE

3504.1 Each enrollee shall be entitled to receive an individual contract, evidence of coverage, or other description of covered services in a form that has been approved by the Commissioner. Each group contract holder shall be entitled to receive a group contract as approved by the Commissioner. Group contracts, individual contracts and evidences of coverage shall be delivered or issued for delivery to enrollees or group contract holders within a reasonable time after enrollment, but not more than fifteen (15) days from the later of the effective date of coverage or the date on which the HMO is notified of enrollment.

3504.2 The group or individual contract and evidence of coverage shall contain the name, address and telephone number of the HMO, and where and in what manner information is available as to how services may be obtained. A telephone number within the service area for calls, without charge to members, to the HMO's administrative office shall be made available and disseminated to enrollees to adequately provide telephone access for enrollee services, problems or

questions.

3504.3 An HMO must provide a method by which the enrollee may contact the HMO, at no cost to the enrollee. This may be done through the use of toll-free or collect telephone calls. The enrollee must be informed of the method by notice in the handbook, newsletter, or flyer. The group or individual contract or evidence of coverage may indicate the manner in which the number will be disseminated rather than list the number itself.

3504.4 The group or individual contract and evidence of coverage shall contain eligibility requirements indicating the conditions that must be met to enroll as a enrollee or eligible dependent, the limiting age for enrollees and eligible dependents including the effects of Medicare eligibility, and a clear statement regarding coverage of newborn children.

3504.5 The group or individual contract and evidence of coverage shall contain a specific description of benefits and services available for emergencies twenty-four (24) hours a day, seven (7) days a week, including disclosure of any restrictions on emergency care services. No group or individual contract or evidence of coverage shall limit the coverage of emergency services within the service area to affiliated providers only.

3504.6 The group or individual contract and evidence of coverage shall contain a description of any limitations or exclusions on the services, kind of services, benefits, or kind of benefits, including any limitations or exclusions due to preexisting conditions, waiting periods or an enrollee's refusal of treatment.

3504.7 No HMO shall cancel or terminate coverage of services provided an enrollee under an HMO group or individual contract except for one or more of the following reasons:

(a) Failure to pay the amounts due under the group or individual contract;

(b) Fraud or material misrepresentation in enrollment or in the use of services or facilities;

(c) Material violation of the terms of the group or individual contract;

(d) Failure to meet the eligibility requirements under a group contract;

(e) Termination of the group contract under which the enrollee was covered;

(f) Failure of the enrollee and the provider to establish a satisfactory patient-provider relationship if:

(1) it is shown that the HMO has, in good faith, provided the enrollee with the opportunity to select an alternative provider;

(2) the enrollee has repeatedly refused to follow the plan of treatment ordered by the provider; and

(3) the enrollee is notified in writing at least thirty (30) days in advance that the HMO considers the patient-provider relationship to be unsatisfactory and specific changes are necessary in order to avoid termination; or

(g) Such other good cause agreed upon in the group or individual contract and approved by the Commissioner.

3504.8 Coverage shall not be cancelled or terminated on the basis of the status of the enrollee's health or because the enrollee has exercised his or her rights under the HMO's grievance procedure by registering a grievance against the HMO.

3504.9 No HMO shall cancel, fail to continue, or terminate an enrollee's coverage for services provided under an HMO group or individual contract without giving the enrollee at least fifteen (15) days written notice of such termination. Notice will be considered given on the date of mailing or, if not mailed, on the date of delivery. This notice shall include the reason. If this action is due to nonpayment of premium, the grace period required in subsections 3504.28 through 3504.30 shall apply.

3504.10 No HMO shall terminate coverage of a dependent child upon attainment of the limiting age stated in the contract if the child is and continues to be both:

(a) Unable to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment(s) which can be

expected to result in death or which has lasted for a continuous period of not less than twelve (12) months; and

(b) Chiefly dependent upon the subscriber for support and maintenance. The term "chiefly dependent" means the certificate holder has listed such child as a dependent on his or her most recent federal and District personal income tax return, and the certificate holder is responsible for providing more than fifty percent (50%) of the child's support.

3504.11 Proof of such incapacity and dependency shall be furnished to the HMO by the enrollee within thirty-one (31) days of the child's attainment of the limiting age and subsequently as reasonably required by the HMO.

3504.12 If an HMO permits reinstatement of an enrollee's coverage, the group or individual contract and evidence of coverage must include any terms and conditions concerning reinstatement. The contract and evidence of coverage may state that all reinstatements are at the option of the HMO and that the HMO is not obligated to reinstate any terminated coverage.

3504.13 The group contract or individual contract and evidence of coverage shall contain procedures for filing claims that include:

(a) Any required notice to the HMO;

(b) If any claim forms are required, how, when and where to obtain and submit them;

(c) Any requirements for filing proper proofs of loss;

(d) Any time limit of payment of claims;

(e) Notice of any provisions for resolving dispured claims, including arbitration; and

(f) A statement of restrictions, if any, on assignment of sums payable to the enrollee by the HMO.

3504.14 A group contract and evidence of coverage shall contain a conversion provision which provides that each enrollee has the right to convert coverage to an individual HMO contract in the following circumstances:

(a) Upon termination of eligibility for coverage under the group contract; or

(b) Upon termination of the group contract.

3504.15 To obtain the conversion contract, an enrollee shall submit a written application and the applicable premium payment to the HMO within thirty-one (31) days after the date the enrollee's eligibility for coverage terminates.

3504.16 A conversion contract shall not be required to be made available if:

(a) The enrollee's termination of coverage occurred for any of the reasons listed in subsection 3504.7(a), (b), (c), (f) or (g);

(b) The enrollee is covered by or is eligible for benefits under Title XVIII of the United States Social Security Act (Medicare);

(c) The enrollee is covered by or is eligible for similar hospital, medical or surgical benefits under District or federal law;

(d) The enrollee is covered by or is eligible for similar hospital, medical or surgical benefits under any arrangement of coverage for individuals in a group;

(e) The enrollee is covered for similar benefits by an individual policy or contract; or

(f) The enrollee has not been continuously covered during the three (3)-month period immediately preceding that person's termination of coverage.

3504.17 The conversion contract shall provide basic health care services to its enrollees as a minimum.

3504.18 The conversion contract shall begin coverage of the enrollee formerly covered under the group contract on the date of termination from such group contract.

3504.19 Coverage shall be provided without requiring evidence of insurability and shall not impose any preexisting condition limitations or exclusions as described in subsections 3513.1 through 3513.3 other than those remaining unexpired under the contract from which conversion is exercised. Any probationary or waiting period set forth in the conversion contract shall be deemed to commence on the effective date of the enrollee's coverage under the prior group contract.

3504.20 If an HMO does not issue individual or conversion contracts, the HMO may use a non-cancelable group contract to provide coverage for enrollees who are eligible for conversion coverage.

3504.21 The group or individual contract and evidence of coverage may contain a provision for coordination of benefits that shall be consistent with that applicable to other carriers in the jurisdiction. Any provisions or rules for coordination of benefits established by an HMO shall not relieve an HMO of its duty to provide or arrange for a covered health care service to any enrollee where the enrollee is entitled to coverage under any other contract, policy or plan, including coverage provided under government programs. The HMO shall be required to provide covered health care services first and then, at its option, seek coordination of benefits.

3504.22 The group or individual contract and evidence of coverage shall not contain any provisions concerning subrogation for injuries caused by third parties unless the wording has been approved by the Commissioner.

3504.23 The group or individual contract shall contain a statement that the contract, all applications and any amendments thereto shall constitute the entire agreement between the parties. No portion of the charter, bylaws or other document of the HMO shall be part of such a contract unless set forth in full in the contract or attached thereto. However, the evidence of coverage may be attached to and made a part of the group contract.

3504.24 The group or individual contract and evidence of coverage shall state the time and date or the occurrence upon which coverage takes effect, including any applicable waiting periods, or describe how the time and date or occurrence upon which coverage takes effect is determined. The contract and evidence of coverage shall also state the time and date or the occurrence upon which coverage will terminate.

3504.25 The group or individual contract shall contain the conditions upon which cancellation or termination may be effected by the HMO, the group contract holder, or the enrollee.

3504.26 The group or individual contract and evidence of coverage shall contain the conditions for, and any restrictions upon, the enrollee's right to renewal.

3504.27 If an HMO permits reinstatement of a group or individual, the contract and evidence of coverage must include any terms and conditions concerning reinstatement. The contract and evidence of coverage may state that all reinstatements are at the option of the HMO and that the HMO is not obligated to reinstate any terminated contract.

3504.28 The group or individual contract shall provide for a grace period of not less than thirty (30) days for the payment of any premium except the first, during which time the coverage shall remain in effect if payment is made during the grace period. The evidence of coverage shall include notice that a grace period exists under the group contract and that coverage continues in force during the grace period.

3504.29 During the grace period the following shall occur:

(a) The HMO shall remain liable for providing the services and benefits contracted for;

(b) The contract holder shall remain liable for the payment of premium for coverage during the grace period; and

(c) The enrollee shall remain liable for any copayments and deductibles.

3504.30 During the grace period, if the premium is not paid and coverage is terminated in accordance with the provisions of the contract, then the contract holder shall be liable for services rendered on a fee for service basis under the usual terms of the contract.

3504.31 If the premium is not paid during the grace period, coverage shall be terminated per the terms of the contract. Following the effective date of such termination, the HMO shall deliver written notice thereof to the contract holder.

3504.32 An individual contract shall contain a provision stating that a person who has entered into an individual contract with a health maintenance organization shall be permitted to return the contract within ten (10) days of receiving it and to receive a refund of the premium paid if the person is not satisfied with the contract for any reason. If the contract is returned to the HMO or to the agent through whom it was purchased, it is considered void from the beginning. However, if services are rendered or claims are paid for such person by the HMO during the

ten (10)-day examination period and the person returns the contract to receive a refund of the premium paid, the person shall be required to pay for such services.

3505 (RESERVED)

3506 PROTECTION AGAINST INSOLVENCY -- NET WORTH AND DEPOSIT REQUIREMENTS, LIABILITIES, AND HOLD HARMLESS

3506.1 An HMO shall have an initial net worth of one million five hundred thousand dollars ($1,500,000) prior to the issuance of the certificate of authority.

3506.2 After the issuance of the certificate of authority an HMO shall maintain a minimum net worth equal to the greater of:

(a) One million dollars ($1,000,000);

(b) Two percent (2%) of the annual dues revenues as reported on the most recent annual statement filed with the Commissioner on the first one hundred fifty million dollars ($150,000,000) of dues plus one percent (1%) of the annual dues in excess of one hundred fifty million dollars ($150,000,000);

(c) An amount equal to the sum of three (3) months uncovered health care expenditures as reported on the most recent financial statement filed with the Commissioner; or

(d) An amount equal to the sum of:

(1) eight percent (8%) of annual health care expenditures except those paid on a capitated basis or a managed hospital payment basis as reported on the most recent financial statement filed with the Commissioner; and

(2) four percent (4%) of annual hospital expenditures paid on a managed hospital payment basis as reported on the most recent financial statement filed with the Commissioner.

3506.3 In determining minimum net worth, no debt shall be considered fully subordinated unless the subordination clause is in a form acceptable to the Commissioner. An interest obligation relating to the repayment of subordinated debt must be similariy subordinated. The interest expenses relating to the repayment of any

fully subordinated debt shall be considered covered expenses. A debt incurred by a note meeting the requirements of section 13 of the Act, D.C. Code § 35-4512, and otherwise acceptable to the Commissioner shall not be considered a liability and shall be recorded as equity.

3506.4 An HMO shall deposit with the Commissioner or, at the discretion of the Commissioner, with any organization or trustee acceptable to the Commissioner through which a custodial or controlled account is utilized, cash, securities, or any combination of these items or other measures that are acceptable to the Commissioner which at all times shall have a value of not less than three hundred thousand dollars ($300,000).

3506.5 The deposit shall be considered an admitted asset of the HMO for purposes of determining its net worth.

3506.6 All income from deposits shall be an asset of the HMO.

3506.7 An HMO that has made a deposit of securities may withdraw the deposit or any part thereof, after making a substitute deposit of cash, securities, or any combination of these or other measures of equal amount and value.

3506.8 All securities must be approved by the Commissioner before being deposited or substituted.

3506.9 The deposit shall be used to offset administrative costs directly related to receivership or liquidation and shall be considered an asset for purposes of liquidation.

3506.10 The HMO's deposit requirement may be reduced or eliminated by the Commissioner if the HMO makes a deposit for the protection of all enrollees with the Commissioner, District treasurer or other District official body, or with the jurisdiction of the HMO's domicile. The deposit shall consist of cash, acceptable securities, or surety and the HMO shall deliver a certificate to that effect to the Commissioner. The certificate shall be authenticated by the regulatory authority of the HMO's domiciliary, or by the appropriate District official holding the deposit.

3506.11 Every HMO shall, when determining liabilities, include an estimated amount in the aggregate to provide for any unearned dues and for the payment of all claims for health care expenditures which have been incurred,

whether reported or unreported, which are unpaid and for which the organization is or may be liable, and to provide for the expense of adjustment or settlement of such claims. Such liabilities may be computed in accordance with generally accepted accounting principles.

3506.12 Every contract between an HMO and participating provider of health care services shall be in writing and shall provide that in the event an HMO fails to pay for health care services as set forth in the contract, the enrollee will not be liable to the provider for any sums owed by the HMO.

3506.13 In the event that the participating provider contract is not in writing or the contract fails to include the prohibition described in subsection 3506.12, the participating provider shall not collect or attempt to collect from the enrollee sums owed by an HMO.

3506.14 No action at law can be brought by the participating provider, agent, trustee or assignee against the enrollee to collect sums owed by the HMO.

3506.15 An HMO shall have an insolvency plan which allows for the continuation of benefits for the duration of the contract period for which premiums have been paid and continuation benefits to members who are confined on the date of insolvency in an inpatient facility until their discharge or expiration of benefits.

3506.16 The Commissioner may require the following item(s) when considering an HMO's insolvency plan:

(a) Insurance to cover the expenses to be paid for continued benefits after insolvency;

(b) Provisions in provider contracts that obligate the provider to provide services for the duration of the period after an HMO's insolvency for which premium payment has been made and until the enrollee's discharge from inpatient facilities;

(c) Insolvency reserves;

(d) Acceptable letters of credit; and

(e) Any other arrangements that to assure a continuation of benefits.

3507 UNCOVERED HEALTH CARE EXPENDITURES INSOLVENCY DEPOSIT

3507.1 An HMO shall place an uncovered health care expenditures insolvency deposit with the Commissioner, or with any organization or trustee acceptable to the Commissioner, when uncovered health care expenditures are more than ten percent (10%) of its total health care expenditures.

3507.2 The uncovered health care expenditures insolvency deposit shall be placed with the Commissioner or in a custodial or controlled account acceptable to the Commissioner.

3507.3 The deposit shall be in the form of cash or securities that are acceptable to the Commissioner.

3507.4 The fair market value of the deposit shall at all times have a fair market value in an amount of one hundred twenty percent (120%) of the HMO's outstanding liability for uncovered health care expenditures for District enrollees. This includes claims incurred, but not reported. The deposit must be calculated as of the first day of each month and maintained for the remainder of the month. If it is not otherwise required to file a quarterly report, the HMO must file a report within forty-five (45) days of the end of the calendar quarter with information sufficient to demonstrate compliance with this section.

3507.5 The deposit required in this section is in addition to the deposit required under section 3506.

3507.6 In determining the net worth of the HMO, the deposit under subsection 3507.4 shall be considered an admitted asset. All income earned from the deposit, or trust accounts established as an alternative to a deposit, is an asset of the HMO. With the approval of the Commissioner, this income may be withdrawn from the deposit or trust account quarterly.

3507.7 The Commissioner shall give prior written approval for all deposits, substitutions or withdrawals.

3507.8 An HMO that has made a deposit may withdraw the entire deposit, or any part of the deposit, if the Commissioner gives prior written approval and if:

(a) A substitute deposit of cash or securities of equal amount and value is made;

(b) The fair market value of the assets and deposit

exceeds the amount of the required deposit; or

(c) The required deposit under subsection 3507.4 is reduced or eliminated.

3507.9 The insolvency deposit is in trust and may be used only as approved by the Commissioner. The Commissioner may use the deposit of an insolvent HMO for administrative costs associated with administering the deposit and payment claims of enrollees of the District for uncovered expenditures. Claims for uncovered expenditures must be paid on a pro rata basis based on assets available to pay such ultimate liability for incurred expenditures.

3507.10 Partial distributions may be made pending final distribution. Any amount of the deposit remaining shall be paid into the liquidation or receivership of the HMO.

3508 MAINTENANCE OF INSUFFICIENT NET WORTH

3508.1 When the Commissioner finds that the net worth maintained by any HMO is less than the minimum net worth required to be maintained under section 3506, the Commissioner shall give written notice to the HMO indicating the amount of the deficiency and require it to file a plan to correct the deficiency. The plan shall be acceptable to the Commissioner. The HMO shall correct the deficiency within a reasonable time not to exceed sixty (60) days, unless the Commissioner grants an extension of time to correct the deficiency.

3508.2 A deficiency in an HMO's net worth will be considered an impairment. An impairment will be grounds for placing the HMO in conservation, rehabilitation, or liquidation, or suspending or revoking its certificate of authority. Noncompliance with the requirements in section 3506 is a prerequisite to suspending or revoking a certificate of authority, denying an application for a certificate of authority or imposing an administrative penalty.

3508.3 When an HMO is impaired and the fact of impairment is known by the HMO or to the person acting on its behalf, no HMO or the person acting on its behalf may, directly or indirectly, renew, issue, or deliver any certificate, agreement, or contract of coverage in the District, for which a premium dues is charged or collected, except for newborn children, other newly acquired dependents of existing enrollees, other newly eligible individuals, or as otherwise allowed by the

Commissioner.

3508.4 The existence of an impairment shall not prevent the issuance or renewal of a certificate, agreement or contract when an enrollee exercises an option granted under the plan to obtain new, renewed, or converted coverage.

3508.5 Suspension or revocation of a certificate of authority, the denial of an application or imposition of an administrative penalty shall be by written order and shall be sent to the HMO by certified or registered mail.

3508.6 The written order shall state the grounds, charges or conduct on which the suspension, revocation, denial of an application, or administrative penalty is based.

3508.7 An HMO or applicant has thirty (30) days from the date of mailing of the order to make a written request for a hearing.

3508.8 An order under subsection 3508.6 shall be final upon the expiration of the thirty (30) days.

3508.9 The procedural requirements for hearings shall be the same as prescribed in section 10 of the District of Columbia Administrative Procedure Act, D.C. Code § 1-1509.

3508.10 When the certificate of authority of an HMO is suspended, the HMO shall not enroll any additional enrollees (except for newborn children, other newly acquired dependents of existing enrollees, or other newly eligible individuals), and shall not engage in any advertising or solicitation whatsoever.

3508.11 When an HMO's certificate of authority is revoked, the HMO shall, immediately following the effective date of the order of revocation:

(a) Immediately wind up its affairs in the District;

(b) Conduct no further business in the District except as may be essential to the orderly conclusion of the HMO's affairs in the District;

(c) Cease advertising or soliciting customers for its services in the District; and

(d) If permitted by written order of the Commissioner, may further operate its business if the

Commissioner finds it to be in the best interest of the HMO's enrollees.

3509 **SERVICES**

3509.1 An HMO shall establish and maintain adequate arrangements to provide health services for its enrollees, including:

(a) Reasonable proximity to the business or personal residences of the enrollees so as not to result in unreasonable barriers to accessibility;

(b) Reasonable hours of operation;

(c) Emergency care services available and accessible within the service area twenty-four (24) hours a day, seven (7) days a week; and

(d) Sufficient providers, personnel, administrators and support staff to assure that all services contracted for will be accessible to enrollees on an appropriate basis without delays detrimental to the health of enrollees.

3509.2 An HMO shall make available to each enrollee a primary care provider and provide accessibility to medically necessary specialists through staffing, contracting or referral. An HMO shall provide for continuity of care for enrollees referred to specialists.

3509.3 An HMO shall have written procedures governing the availability of services utilized by enrollees, including at least the following:

(a) Well-patient examinations and immunizations;

(b) Emergency telephone consultation on a twenty-four (24) hours per day, seven (7) days per week basis;

(c) Treatment of emergencies;

(d) Treatment of minor illnesses; and

(e) Treatment of chronic illnesses.

3509.4 An HMO shall provide, or arrange for basic health care services, which shall include preventive care, emergency care, inpatient and outpatient hospital and physician care, diagnostic laboratory and diagnostic and therapeutic radiological services, and services

mandated under the:

(a) Drug Abuse, Alcohol Abuse, and Mental Illness Insurance Coverage Act of 1986, D.C. Law 6-195, D.C. Code § 35-2301 et seq.;

(b) Newborn Health Insurance Act of 1979, D.C. Law 3-33, D.C. Code § 35-1101 et seq.; and

(c) District of Columbia Cancer Prevention Act of 1990, D.C. Law 8-225, D.C. Code § 35-1101 et seq.

3509.5 Out-of-area services shall be subject to the copayment requirements set forth in the group and individual contract and evidence of coverage.

3509.6 When an enrollee is temporarily out of an HMO's service area, the HMO shall provide benefits for reimbursement for emergency care services and emergency transportation which is medically necessary and appropriate under the circumstances, and in the event that emergency care services are provided and further inpatient care is medically necessary, once the enrollee is stabilized, the HMO shall provide benefits for reimbursement for transportation to return the enrollee to an HMO provider, subject to the following conditions:

(a) The condition could not reasonably have been foreseen;

(b) The enrollee could not reasonably arrange to return to the service area to receive treatment from the HMO's provider;

(c) The travel or temporary departure outside of the service area must be for some purpose other than the receipt of unapproved medical treatments; and

(d) The HMO is notified by telephone within twenty-four (24) hours of the commencement of such care unless it is shown that it was not reasonably possible to communicate with the HMO within such time limits, if the HMO requires such notification.

3510 **FILING REQUIREMENTS FOR RATING INFORMATION**

3510.1 A schedule of enrollment fees or methodology for determining enrollment fees due must be filed and approved by the Commissioner before the fees can be used by the HMO.

3510.2 Either a specific schedule of fees, or a methodology for determining fees, shall be established in accordance with actuarial principles for various categories of enrollees, provided that the enrollment fees applicable to an enrollee shall not be individually determined based on the status of an enrollee's health.

3510.3 Enrollment fees shall not be excessive, inadequate or discriminatory.

3510.4 A statement by a qualified actuary or other qualified person acceptable to the Commissioner as to the appropriateness of the use of the methodology based on reasonable assumptions, shall accompany the schedule of fees along with adequate supporting information.

3510.5 When a schedule of enrollment fees or a method of determining enrollment fees filed by an HMO is disapproved by the Commissioner, written notice specifying the reasons for the disapproval shall be sent to the HMO. A hearing will be held within thirty (30) days after a request in writing for a hearing by the person submitting the fee schedule or methodology. The schedule or methodology is considered approved by the Commissioner if the Commissioner takes no action on the schedule or methodology within thirty (30) days of its filing.

3511 READABILITY STANDARDS FOR INDIVIDUAL OR GROUP CONTRACTS AND EVIDENCE OF COVERAGE

3511.1 Each individual or group contract, or evidence of coverage, shall include a table of contents.

3511.2 Each section in the aforementioned documents shall be self-contained and independent, and any section may cross-reference another section or sections when necessary and appropriate. However, general provisions applicable to more than one section may be included in a common section.

3511.3 The group or individual contracts and the evidence of coverage shall be printed in ten (10) point type or more.

3511.4 The group or individual contract and evidence of coverage shall be printed in a legible type style with adequate contrast between ink and paper. Captions, headings, and spacing shall be used to increase overall

legibility.

3511.5 The group or individual contracts and evidence of coverage shall be written in everyday conversational language.

3511.6 Technical terms and words with special meaning shall be avoided wherever possible. If a technical word is used, it should be clearly defined in the document.

3511.7 The group or individual contract and evidence of coverage must earn at least a score of forty on the Flesch Reading Ease Test or an equivalent score on any other comparable test, or a lower score on either if the Commissioner finds the policy or document reasonably easy to read.

3511.8 The Flesch Reading Ease Test will be scored by the following method:

(a) For a group or individual contract, or evidence of coverage, that contains ten thousand (10,000) words or less of text, the entire document will be analyzed. For a group or individual contract, or evidence of coverage, containing more than ten thousand (10,000) words, the readability of two one hundred (100) word samples per page may be analyzed instead. The samples must be separated by at least twenty (20) printed lines;

(b) The total number of words in the text or sample shall be divided by the total number of sentences. The figure so obtained shall then be multiplied by 1.015;

(c) The total number of syllables in the text or sample shall be divided by the total number of words. The figure so obtained shall then be multiplied by 84.6; and

(d) The sum of the figures computed under (b) and (c) shall then be subtracted from 206.835 to determine the Flesch Reading Ease Test score.

3511.9 For purposes of subsection 3511.8, the following procedures shall be used:

(a) A contraction, hyphenated word, numbers, and letters, when separated by spaces, shall be counted as one word.

(b) A unit of text ending with a period, semi-colon,

or colon shall be counted as a sentence.

(c) A syllable means a unit of spoken language consisting of one or more letters of a word as identified in a recognized dictionary.

3512 **POINT OF SERVICE PLAN**

3512.1 If an employer, association, or other private group arrangement offers health benefit plan coverage to employees or individuals only through an HMO, the HMO with which the employer, association, or other private group arrangement is contracting for the coverage shall offer, or contract with another carrier to offer, a point-of-service option to the employer, association, or other private group arrangement in conjunction with the HMO as an additional benefit for an employee or individual, at the employee's or individual's option to accept or reject.

3512.2 An employee or individual who accepts the point of service option may be required to pay a premium over the amount of the premium for the coverage offered by the HMO.

3512.3 Different cost-sharing provisions may be imposed by the HMO based on whether service is provided by the HMO's provider panel or by an out-of-network provider panel.

3512.4 This section only applies to renewal or new subscriber contracts issued after April 9, 1997.

3512.5 This section does not apply to individual subscriber contracts issued to a person who is not part of a contracted group of subscribers.

3513 **PROHIBITED PRACTICES**

3513.1 An HMO may include in its individual contract a provision setting forth reasonable exclusions or limitations of services for preexisting conditions at time of enrollment. However, no such exclusions or limitations shall be for a period greater than twelve (12) months for enrollees or eighteen (18) months for late enrollees.

3513.2 No HMO shall exclude or limit services for a preexisting condition when the enrollee transfers coverage from one individual contract to another or when the enrollee converts coverage under his conversion option, except to the extent of a preexisting condition limitation or exclusion remaining

unexpired under the prior contract. Any required probationary or waiting period shall be deemed to have commenced on the effective date of coverage under the prior contract. The HMO contract shall disclose any preexisting condition limitations or exclusions that are applicable when an enrollee transfers from a prior HMO contract.

3513.3 No HMO shall discriminate against any enrollee or applicant seeking enrollment for reasons other than that of the enrollee's or applicant's own merit. This includes, but is not limited to, discrimination by reason of race, color, religion, national origin, sex, age, marital status, personal appearance, sexual orientation, family responsibilities, matriculation, political affiliation, disability, source of income and place of residence or business, or because of the frequency of utilizatiion of services by an enrollee. Further, nothing shall prohibit an HMO from setting rates or establishing a schedule of charges in accordance with relevant actuarial data.

3513.4 No HMO shall expel or refuse to re-enroll any enrollee nor refuse to enroll individual members of a group on the basis of the health status or health care needs of the individuals or enrollees.

3514 OTHER REQUIREMENTS

3514.1 An HMO shall provide its enrollees with a list of the names and locations of all of its participating providers no later than the time of enrollment or the time the group or individual contract and evidence of coverage are issued, whichever is later. An HMO shall also provide its enrollees with such a list upon reenrollment, if requested. If a primary care provider ceases to be affiliated with an HMO, the HMO shall provide notice of such cessation to its affected enrollees within thirty (30) days of its occurrence. Subject to the approval of the Commissioner, an HMO may provide its enrollees with a list of providers or provider groups for a segment of the service area. However, a list of all providers shall be made available to subscribers upon request.

3514.2 Any list of participating providers shall contain a notice regarding the availability of the listed primary care providers. Such notice shall be in not less than twelve (12) point type and be placed in a prominent place on the list of providers. The notice shall contain the following or similar language:

Enrolling in [name of HMO] does not guarantee services by a particular provider on this list. If you wish to receive care from specific providers listed, you should contact those providers to be sure that they are accepting additional patients for [name of HMO].

3514.3 An HMO may require copayments or deductibles of enrollees as a condition for the receipt of specific health care services. Copayments for basic health care services shall be shown in the group or individual contract and evidence of coverage as a specified dollar amount.

3515 REGULATION OF HMO PRODUCERS

3515.1 No person shall act or hold himself to be an HMO producer unless duly licensed and appointed as such in accordance with these rules.

3515.2 No HMO doing business in the District of Columbia shall pay, directly or indirectly, any commission for any reason or purpose to any person, other than as may be permitted hereunder, nor shall any such HMO pay, directly or indirectly, any commission, or other valuable consideration, to any person for services as an HMO producer within the District of Columbia, unless such person shall hold a currently valid license to act as an HMO producer as required by the Act and these rules and is appointed by such HMO under that license. Neither shall any person, other than a duly licensed HMO producer or any person permitted hereunder, accept any such commission or other valuable consideration; provided, however, that the provisions of this section shall not prevent the payment or receipt of renewal or other deferred commissions to or by any person solely because such person has ceased to hold a license to act as an HMO producer.

3515.3 No HMO producer shall pay, allow, give or offer to pay, allow or give, directly or indirectly, any rebate of premiums or membership fees payable, any commission, any paid employment or contract for service of any kind, or any valuable consideration or inducement whatever, that is not specified in the policy or contract for health services, for or on account of the solicitation or negotiation of such contracts or policies, other than to another HMO producer.

3515.4 None of the following shall be required to hold an HMO producer license:

(a) Any regular salaried officer or employee of an HMO who devotes substantially all of his or her time to activities other than the taking or transmitting of applications or membership fees or premiums for HMO membership, and who receives no commission or other compensation directly dependent upon the business obtained and who does not solicit or accept from the public applications for HMO membership;

(b) Employers or their officers or employees, or the trustees of any employee benefit plan, to the extent that such employers, officers, employees, or trustees are engaged in the administration or operation of any program of employee benefits involving the use of HMO memberships; provided that such employers, officers, employees or trustees are not in any manner compensated directly or indirectly by the HMO issuing such HMO memberships;

(c) Banks or their officers and employees to the extent that such banks, officers and employees collect and remit charges by debiting the charges against accounts of depositors on the orders of such depositors; or

(d) Any person or the employee of any person who has contracted to provide administrative, management or health care services to an HMO and who is compensated for those services by the payment of an amount calculated as a percentage of the revenues, net income or profit of the HMO, if that method of compensation is the sole basis for subjecting that person or the employee of that person, to the licensure provisions of this Act.

3515.5 An individual applying for an HMO producer license shall pass a written examination to the satisfaction of the Commissioner for life and health licensure unless exempt pursuant to subsection 3515.10 or subsection 3515.24.

3515.6 The Commissioner may make arrangements, including contracting with an outside testing service, for administering examinations and collecting the fee for the examination.

3515.7 Each individual applying for an examination shall remit the fee as prescribed by the Commissioner in accordance with the provisions of subsection 3515.36.

3515.8 A new examination fee shall be paid for each examination. The examination fee shall not be returned for any reason other than for failure to appear and take the examination after the applicant has given at least twenty-four (24) hours notice to the Commissioner of an emergency situation and received the Commissioner's written approval.

3515.9 An individual who files a letter of clearance with the Commissioner certifying that he held a license in good standing to act as an HMO producer in his prior state of licensure, which license was obtained by passing a written examination relating to the conduct of HMO business, shall take an examination pertaining only to the District of Columbia's laws and rules relating to the conduct of HMO business.

3515.10 No examination shall be required of a partnership or a corporation.

3515.11 When any individual, partnership or corporation desires to obtain a license as an HMO producer, that person shall file an application with the Department.

3515.12 Upon receipt of an acceptable application for an HMO producer license, the Commissioner shall issue a license to the applicant, unless such application is denied under subsection 3510.37, if it finds that the applicant is:

(a) An individual who:

(1) is at least eighteen (18) years of age;

(2) has completed a prelicensing course of study approved by the Commissioner;

(3) has paid the fee as prescribed in subsection 3515.36; and

(4) has successfully passed the examination required under subsection 3515.5; or

(b) A general partnership, of which all persons interested as partners are duly licensed as HMO producers under the Act and these rules; or

(c) A District of Columbia corporation which:

(1) Is organized and existing under the District of Columbia corporation statutes;

(2) Has its principal place of business in the

District of Columbia;

(3) Has as one of its purposes the authority to act as an HMO producer;

(4) Has each of its officers, directors and shareholders duly licensed as HMO producers;

(5) Has agreed to notify the Commissioner of any change in officers, directors or shareholders not later than thirty (30) days after the date on which the change becomes effective; and

(6) Has designated an officer responsible for demonstrating the corporation's compliance with the applicable laws of the District of Columbia relating to the conduct of HMO business.

3515.13 An HMO producer must demonstrate financial responsibility to the satisfaction of the Commissioner that the HMO producer has reasonably provided for the protection of its customers in the event of some negligent act, error or omission. Such financial responsibility may be demonstrated by a bond or a deposit.

3515.14 Nothing herein shall be construed to permit any unlicensed employee of any licensed individual, partnership or corporate HMO producer to perform any act of an HMO producer without such employee's first obtaining an HMO producer license.

3515.15 If at any time, any individual, partnership or corporation holding an HMO producer license does not maintain the qualifications necessary to obtain such a license, the HMO producer's license may be revoked under the provisions of subsection 3515.37; provided, however, that should any person who is not a licensed HMO producer obtain shares in such a corporation by devise or descent, the person shall have a period of thirty (30) days from date of acquisition within which to obtain a license as an HMO producer, unless exempted under subsection 3515.20.

3515.16 The Commissioner shall require any document reasonably necessary to verify the information contained in a person's application for licensure.

3515.17 The Commissioner shall cause to be issued to qualified HMO producers a license which shall contain the

producer's legal name, address of record, license identification number and license expiration date.

3515.18 Persons holding an HMO producer's license shall inform the Department in writing promptly, not to exceed thirty (30) days, of any change in the address at which the Commissioner shall be able to send official notifications.

3515.19 Persons holding an HMO producer's license shall notify the Commissioner on a form specified by the Department of all office locations maintained for the purpose of operating as an HMO producer, and of all names other than such person's exact legal name in which such person intends to act as an HMO producer. A fee as specified in subsection 3510.36 shall accompany any such filing. No HMO producer may operate from any location or under any name other than the HMO producer's legal name prior to making the filing provided herein. An HMO producer shall promptly notify the Commissioner in writing when it ceases to do business under a particular trade name or from a particular location.

3515.20 In the event an individual who is duly licensed as an HMO producer conveys some or all of his interest in his business, while living, to his children or dependents or to a trust for such children or dependents or, upon death, to his surviving spouse, children or dependents or to a trust for such surviving spouse, children or dependents, such spouse, children, dependents or trusts may participate in the profits of such business during their lifetime without first qualifying as an HMO producer, subject to the following conditions:

(a) That such business shall be continued by a duly qualified and licensed HMO producer;

(b) That such surviving spouse, children, dependents or trusts shall perform no act of an HMO producer without first becoming duly licensed as an HMO producer;

(c) That all trustees of any trusts as described herein must be duly licensed as HMO producers; and

(d) That the individual HMO producer conveying such interest is either:

(1) A sole proprietor;

(2) A partner in a licensed partnership, where a

written partnership agreement or, in the absence of such agreement, an agreement between the surviving partner or partners and the surviving children or dependents, as appropriate, provides for such conveyance; or

(3) A shareholder in a licensed corporation, where a contract entered into by and between all of the shareholders and the corporation provides for such conveyance.

3515.21 Unless suspended, revoked or cancelled pursuant to subsection 3515.37, each license issued to an HMO producer shall expire on the 30th day of April of each odd numbered year, unless an application for renewal of any such license is filed with the Commissioner and the required fee is paid on or before such date. Once such application for renewal is received, such license shall continue in full force unless, pursuant to subsection 3510.37, the application for renewal is denied.

3515.22 A request for license continuation which is received by the Commissioner within 30 days after the expiration date may be effectuated if accompanied by a continuation fee two (2) times the amount otherwise required, except that the Commissioner may waive imposition of the additional fee based on good cause shown for the delay.

3515.23 If a license has been expired for longer than one (1) year, it may not be renewed. A new license may be obtained by complying with the requirements and procedures for obtaining an original license, including passing the examination required in subsection 3515.5.

3515.24 A person who is not a resident of the District may apply for licensing as an HMO producer if such person otherwise complies with the Act and these rules.

(a) If the state in which such applicant resides requires HMO producers to hold a license and to qualify for such license by passing a written examination covering HMO topics, substantially similar to the examination required under section 3515.5 of these rules, the appropriate official of the other state must certify that the applicant holds a currently valid license to act as an HMO producer in such state by passing a written examination or holds a currently valid license issued because of the applicant's exemption from the requirements of an examination. If a person

holds an HMO producer's license issued by another state in accordance with the requirements as set forth in this paragraph, such person shall be eligible to receive a license by waiver without taking the Commissioner's examination.

(b) If the state in which such applicant resides requires HMO producers to hold a license, but does not require such producers to qualify by passing a written examination covering HMO topics, the appropriate official of the other state must certify that the applicant holds a currently valid license to act as an HMO producer, and the applicant must pass the Commissioner's examination as prescribed in subsection 3515.5.

(c) If the state in which such applicant resides does not require HMO producers to hold a license, the applicant must pass the examination as prescribed in subsection 3515.5.

3515.25 The applicant shall file with the Commissioner the required forms appointing the Commissioner and his successor in office as such nonresident's agent upon whom all lawful process in any legal or administrative proceeding against the nonresident may be served, and shall agree that any such lawful process has the same legal force and validity as personal service of process upon such nonresident. The Commissioner shall, within five (5) working days after receiving process, forward a copy of such process by registered or certified mail to the person for whom he has received such process at the nonresident's address of record.

3515.26 The state in which the applicant resides shall permit a resident HMO producer of the District of Columbia to obtain a similar license in that other state under conditions substantially equivalent to the above, and without discrimination in favor of the residents of that other state; provided, however, that whenever, by the laws or regulations of any other state, any limitation of rights and privileges, conditions precedent, fees, or any other requirements are imposed upon residents of the District who are nonresidents or licensees of such other state in addition to, or in excess of, those imposed on nonresidents under this section, the same such requirements shall be imposed upon such residents of such other state. The Commissioner may enter into reciprocal agreements with the appropriate official of any state wherein such eligibilities are stipulated and recognized.

3515.27 No HMO producer shall claim to be a representative of, an authorized or appointed producer of, or other term implying a contractual relationship with a particular HMO or solicit or accept applications for HMO membership for such HMO, unless such HMO producer becomes appointed by that HMO pursuant to this section.

3515.28 In order to appoint an HMO producer the HMO shall, immediately upon executing a producer contract or upon accepting the first HMO membership application from a licensed HMO producer, whichever is earlier, file with the Commissioner a written notice of appointment on a form prescribed by the Commissioner.

(a) Two or more HMOs in an affiliated group may appoint a licensed HMO producer by filing a single notice of appointment on a form prescribed by the Department.

(b) Each notice of appointment delivered to the Commissioner shall be accompanied by an appointment fee, in the amount set forth in subsection 3510.36 for each HMO appointing the HMO producer.

(c) HMOs appointing an HMO producer under this subsection shall, not later than five (5) days after filing the required notice of appointment with the Commissioner, deliver a copy of such notice of appointment to the HMO producer.

3515.29 Upon receipt of the notice of appointment, the Commissioner shall, within thirty (30) business days, send written verification to the appointing HMO or HMOs of whether the licensed HMO producer is eligible for appointment; provided, however, that if such verification is not sent by the Commissioner within thirty (30) business days from the date the notice of appointment was received by the Department, the appointing HMO or HMOs may consider the appointment approved, and the licensed HMO producer, if so advised by the HMO or HMOs, may act as an appointed HMO producer of such HMO or HMOs unless and until subsequently advised that the appointment is disapproved.

3515.30 The appointing HMO or HMOs shall, within five (5) days of receipt of verification of an HMO producer's appointment status from the Commissioner, forward a copy of such verification to the licensed HMO producer. If the licensed HMO producer does not receive from the HMO a copy of verification of approval of such

appointment or appointments within thirty (30) days from the date the notice of appointment is filed by the HMO, then the HMO producer shall immediately discontinue acting as an HMO producer on behalf of such HMO or HMOs until such verification of approval is received.

3515.31 Thirty (30) days prior to the renewal date, every HMO shall remit, in a manner prescribed by the Commissioner, a renewal appointment fee in the amount set forth in subsection 3510.36.

3515.32 An HMO producer's appointment with a specific HMO shall be terminated upon the filing of written notification in such form as the Commissioner may prescribe by:

(a) The HMO producer, upon delivering such notification to the Commissioner and to the HMO; or

(b) The HMO, upon delivering such notification to the Commissioner and to the HMO producer.

3515.33 Upon the termination of an appointed HMO producer by an HMO, the HMO shall provide the Commissioner with a statement of the facts relative to the termination of the appointment and the date and reason for such termination. If the HMO producer was terminated for cause, the HMO shall further provide such additional information, documents, records or other data pertaining to the termination which may be used by the Commissioner in any action taken pursuant to section 3510.37 of these rules.

3515.34 Any information, documents, records or statements provided to the Commissioner pursuant to this section shall be deemed to be a confidential and privileged communications unless or until introduced as evidence in an administrative hearing or admitted into evidence in a court action or proceeding pursuant to subpoena of a court of record.

3515.35 There shall be no liability on the part of, nor shall a cause of action of any nature arise against the Commissioner, the HMO or an authorized representative of either, or any other person, so long as they are acting in good faith and without malice, relative to the transmission of any information, documents, records or statements required to be disclosed pursuant to this section.

3515.36 The Commissioner shall collect the following

nonrefundable fees:

(a) Initial HMO producer license fee, $100.00.

(b) Duplicate HMO producer license fee, $50.00.

(c) HMO producer license renewal fee, $100.00.

(d) Initial HMO producer appointment fee, $25.00.

(e) HMO producer appointment renewal fee, $25.00.

3515.37 The licensure of any HMO producer may be denied, or a license duly issued may be suspended or revoked or the renewal thereof denied by the Commissioner if, after notice and hearing as provided in section 10 of the District of Columbia Administrative Procedure Act, D.C. Code § 1-1509, the Commissioner finds that the applicant for or holder of such license, whether individually or through any officer, director, shareholder, partner or employee:

(a) Has violated any provision of District law, any federal law, any law of another state law, or any regulation or order of the Commissioner, except for violation which the Commissioner determines would be inappropriate reasons for suspending or revoking the producer's license;

(b) Has intentionally made a material misstatement in the application for such license;

(c) Has obtained, or attempted to obtain, such license by fraud or misrepresentation;

(d) Has misappropriated or converted to his, her, or an HMO's own use, or illegally withheld, money belonging to an applicant for HMO membership or to an HMO member or enrollee;

(e) Has shown himself or herself to be financially irresponsible or has otherwise demonstrated lack of trustworthiness or competence to act as an HMO producer;

(f) Has been guilty of fraudulent or dishonest practices relative to the conduct of HMO business;

(g) Has materially misrepresented the terms and conditions of HMO membership contracts;

(h) Has made or issued, or caused to be made or issued, any false statement or misrepresentation of a material nature regarding the terms or conditions of any health coverage contract issued by an insurer or HMO, for the purpose of inducing or attempting to induce the owner of such contract to forfeit or surrender such contract or allow it to lapse for the purpose of replacing such contract with an HMO membership contract;

(i) Has obtained, or attempted to obtain such license, not for the purpose of holding himself out to the public as an HMO agent, but primarily for the purpose of soliciting, negotiating or procuring HMO membership contracts covering himself or members of his family or his business associates; or

(j) Has been convicted of a felony.

3515.38 In lieu of, or in addition to suspension, revocation, or noncontinuation of a license, the Commissioner may impose a civil penalty of not more than $5,000 upon a licensee whose license is subject to suspension, revocation, or noncontinuation under this section, and may additionally require restitution to any person who has suffered financial injury or damage as a result of the violation of any provision of the Act.

3515.39 No applicant or licensee whose licensure has been denied, refused or revoked under subsection 3510.37 is entitled to file another application for a license as an HMO producer within three (3) years from the date on which such denial, refusal or revocation becomes final. Such application, when filed after three (3) years, may be denied by the Commissioner unless the applicant shows good cause why the denial, refusal or revocation of his license should not be considered a bar to the issuance of a new license.

3515.40 The Department shall adopt a procedure for certifying and shall certify continuing education programs for HMO producers by fiscal year 2000. No HMO producer shall be required to complete more than 16 hours of continuing education during any twenty-four month period for maintenance of its HMO producer license.

3516 **POWERS OF INSURANCE CORPORATIONS**

3516.1 An insurance company licensed to do business in the District may organize and operate an HMO directly, through a subsidiary or affiliate, pursuant to section

18 of the Act, D.C. Code § 35-4517.

3516.2 Any two (2) or more insurance companies licensed to do business in the District, or subsidiaries or affiliates of these companies, may jointly organize and operate an HMO.

3516.3 An insurer may contract with an HMO to render insurance or similar protection against the costs of care provided through HMOs and to provide coverage in the event of the failure of an HMO to meet its obligations.

3516.4 Under such contracts, the insurer may make benefit payments to HMOs for health care services rendered by providers.

3517 DENIAL, SUSPENSION OR REVOCATION OF THE CERTIFICATE OF AUTHORITY

3517.1 The Commissioner may deny an application for a certificate of authority, and suspend or revoke a certificate of authority issued under the Act and these rules, for the following reasons:

(a) The HMO is operating in a manner that is significantly inconsistent with its basic organizational documentation;

(b) The HMO fails to comply with section 8 of the Act, D.C. Code § 35-4507 (requirements for group contract, individual contract, and evidence of coverage) and section 16 of the Act, D.C. Code § 35-4515 (filing requirements for rating information);

(c) The HMO does not provide or arrange for basic health care services;

(d) The Commissioner certifies that the HMO does not meet the requirements for issuance of a certificate of authority under section 3501.5, or it is unable to meet its obligations to provide health care services;

(e) The HMO is no longer financially sound;

(f) The HMO does not correct any deficiency occurring due to the HMO's prescribed minimum net worth being impaired;

(g) The HMO has failed to implement the grievance procedure as required under section 11 of the Act,

D.C. Code § 35-4510, in reasonable manner to resolve legitimate complaints;

(h) The HMO or any person authorized to act on its behalf, has advertised or merchandised its services in an untrue, misrepresentative, misleading, deceptive, or unfair manner;

(i) The HMO's continued operation would be dangerous to its enrollees; or

(j) The HMO has otherwise failed substantially to comply with the Act and these rules.

3517.2 In addition to, or in lieu of suspension or revocation of a certificate of authority, the applicant or HMO may be subject to an administrative penalty up to $1,000 a day for each cause for suspension or revocation.

3518 INVESTMENTS

3518.1 The funds of an HMO shall be invested in accordance with section 5(a)(1) of the Act, D.C. Code § 35-4504(a)(1), or the HMO Investment Guidelines adopted by the Commissioner.

3519 FORMS

3519.1 Each form submitted by an HMO for the purpose of receiving a certificate of authority must be in duplicate. It also must have a letter that lists each form with a brief description of it. The Commissioner will retain one copy of each submittal in the original form or on microfilm. The second copy will be returned to the HMO in a self-addressed, postage prepaid envelope. The forms returned to the HMO will have either a notation indicating approval or disapproval. The form disapproved by the Commissioner may not be used by the HMO. The approved forms must be maintained by the HMO.

3520 REVIEW OF COMPLAINTS BY THE COMMISSIONER

3520.1 Any person, group, association, corporation, or other entity having exhausted the HMO's internal grievance and appeals procedure, unless no process exists, or exhaustion would be futile, may file a written complaint with the Commissioner regarding an HMO's compliance with the District of Columbia HMO laws and regulations. The complaint shall state the grounds and pertinent underlying facts, the names of all relevant persons involved, the status of all appropriate

internal grievances and appeal procedures, and whether those procedures have been exhausted. This subsection shall not apply to appeals and grievances filed pursuant to the Health Benefits Plan Members Bill of Rights Act of 1998, effective April 27, 1999, D.C. Law 12-274, D.C. Code § 32-571.1 et seq.

3520.2 The Commissioner may initiate investigations when, based on a report, a complaint, or any other information, the Commissioner has reason to believe that an HMO or producer subject to the laws and regulations of the District is not in compliance such provisions. The Commissioner shall notify the HMO or producer in writing that an investigation has been initiated, and shall include in such notice a full statement of the pertinent facts, the matter being investigated, and a statement that the entity may submit a written report concerning such matters to the Commissioner within thirty (30) days from the date of the notice. The Commissioner will obtain any information considered necessary, and may employ site visits, public hearings, or any other procedures considered appropriate.

3521 **PUBLIC DOCUMENTS**

All applications, filings, and reports required under the Act shall be treated as public documents, except those which are trade secrets, privileged or quality assurance, commercial, and financial information, other than any annual financial statement that may be required under section 9 of the Act, D.C. Code § 35-4508.

3599 **DEFINITIONS**

3599.1 "Act" means the Health Maintenance Organization Act of 1996, effective April 9, 1997, D.C. Law 11-235, D.C. Code § 35-4500 et seq.

3599.2 "Annual Dues Revenues" means sources of income received by the Health Maintenance Organization (HMO) for health services provided to members or in certain situations, non-members. These balances are found in the National Association of Insurance Commissioners' (NAIC) HMO annual statement blank.

3599.3 "Annual Health Care Expenditures except those expenses paid on a capitated basis or managed hospital payment basis" means the health-related expenditures of the health maintenance organization which are paid on a fee-for-service or non-managed care basis annually.

These balances are found in the National Association of Insurance Commissioners' (NAIC) HMO annual statement blank.

3599.4 "Annual Health Care Expenditures paid on a capitated basis or managed hospital payment basis" means the health expenditures of the HMO used to provide covered services to its enrollees which are included within the capitated or contractual arrangement the HMO has with its providers and participating hospitals. These balances are found in the National Association of Insurance Commissioners' (NAIC) HMO annual statement blank.

3599.5 "Annual Hospital Expenditures paid on a managed hospital payment basis" means the inpatient hospital costs of routine and ancillary services provided to members of the Health Maintenance Organization while confined to an acute care hospital. This excludes emergency room and out-of-area hospitalization. However, these expenditures may include and not be limited to capitation payments, diagnostic related group ("DRG") type payments, case rate type payments, discounted fee-for-service payments, per diem arrangements, and similar arrangements in which payment is not based on usual, reasonable and customary fees for services rendered. When filing rates, accompanied with an actuarial memorandum, the memorandum shall clearly state whether the definition of "annual hospital expenditures" is used in the rates that are filed. The actuary shall state which components of the definition are included and which are excluded from the rates that are filed. These balances are found in the National Association of Insurance Commissioners' (NAIC) HMO annual statement blank.

3599.6 "Appointed producer" means a licensed HMO producer who conducts business within the scope of his or her license and who is appointed by an HMO to solicit, negotiate, effect, procure, deliver, renew or continue HMO membership contracts on behalf of the appointing HMO or who takes or transmits a membership fee or premium for such contract, other than for himself, or a person who advertises or otherwise holds himself or herself out to the public as an appointed producer.

3599.7 "Basic Health Care Services" means preventive care, emergency care, inpatient and outpatient hospital and physician care, diagnostic laboratory and diagnostic and therapeutic radiological services, and services mandated under the Drug Abuse, Alcohol Abuse, and

Mental Illness Insurance Coverage Act of 1986, effective February 28, 1987, D.C. Law 6-195, D.C. Code, § 35-2301 et seq.; the Newborn Health Insurance Act of 1979, effective October 20, 1979, D.C. Law 3-33, D.C. Code § 35-1101 et seq.; and the District of Columbia Cancer Prevention Act of 1990, effective March 7, 1991, D.C. Law 8-225, D.C. Code § 35-2402 et seq.

3599.8 "Copayment" means either a dollar or percentage amount an enrollee must pay in order to receive a specific covered service which is not fully prepaid.

3599.9 "Customer" means any person to whom an HMO producer sells or attempts to sell an HMO membership contract, or from whom an HMO producer accepts an application for such a contract.

3599.10 "Deductible" means the amount an enrollee is responsible to pay out-of-pocket before the HMO begins to pay the costs or provide the services associated with treatment.

3599.11 "Department" means the Department of Insurance and Securities Regulation.

3599.12 "Emergency Care Services" means:

(a) Health care services furnished in the emergency department of a hospital for the treatment of a medical emergency;

(b) Ancillary services routinely available to the emergency department of a hospital for the treatment of a medical emergency; and

(c) Emergency medical services transportation.

3599.13 "Enrollee" means an individual covered under a group or nongroup HMO contract.

3599.14 "Evidence of Coverage" means a statement of the essential features and services covered of the HMO which is given to the enrollee by the HMO or by the group contract holder.

3599.15 "Firm" means a health maintenance organization.

3599.16 "Group Contract" means a contract issued and delivered in the District for health care services which by its terms limits eligibility to members of a specified group. The group contract may include coverage for dependents.

3599.17 "Group Contract Holder" means the person to which a group contract has been issued.

3599.18 "Health Maintenance Organization" or "HMO" means any person that undertakes to provide or arrange for the delivery of basic health care services to enrollees on a prepaid basis, except for enrollee responsibility for copayments and/or deductibles.

3599.19 "HMO Producer" means a person who solicits, negotiates, effects, procures, delivers, renews or continues a policy or contract for HMO membership, or who takes or transmits a membership fee or premium for such a policy or contract, other than for himself or herself, or a person who advertises or otherwise holds himself or herself out to the public as an HMO Producer.

3599.20 "Hospital" means a duly licensed institution which provides general and specialized inpatient medical care. The term "hospital" shall not include a convalescent facility, nursing home, or any institution or part thereof which is used principally as a convalescent facility, rest facility, nursing facility or facility for the aged.

3599.21 "Individual" means a natural person.

3599.22 "Individual contract" means a contract delivered in the District for health care services issued to and covering an individual enrollee. The individual contract may include dependents of the enrollee.

3599.23 "License" means a document or certificate of authority issued by the Department authorizing a person to act as an HMO producer.

3599.24 "Participating provider" means a provider who, under an express or implied contract with the HMO or with its contractor or subcontractor, has agreed to provide covered services to enrollees with an expectation of receiving payment, other than copayments or deductibles, directly or indirectly from the HMO.

3599.25 "Person" means any natural person, corporation, association, partnership or other legal entity.

3599.26 "Primary care provider" means a participating provider whom the enrollee has selected, or who has otherwise been assigned responsibility, for the coordination of covered services to the enrollee.

3599.27 "Provider" means any hospital or health professional

licensed or authorized by reciprocity or endorsement to practice a health occupation by the District pursuant to the Health Occupations Revision Act of 1985, effective March 25, 1986, D.C. Law 6-99, D.C. Code § 2-3301.1 et seq., or any state.

3599.28 "Service area" means the District of Columbia.

3599.29 "Subscriber contract" means an individual whose employment or other status, except family dependency, is the basis for eligibility for enrollment in the HMO, or in the case of an individual contract, the person in whose name the contract is issued.

3599.30 "Text" means all printed matter except: the name and address of the HMO; the name, number, or title of the documents; the table of contents or index; the heading and captions; the defined terms; the proper nouns; and the declarations pages, schedules or tables.

3599.31 "Uncovered Health Care Expenditures" means the cost of health-related expenditures that are the obligation of the health maintenance organization for which an enrollee may also be liable in the event of the HMO's insolvency.